2017 Open Enrollment Form – State of New Hampshire SAG Employees

A

☐ New Enrollment (check all that apply)
☐ Newly Enrolling Self
☐ Newly Enrolling Spouse
☐ Newly Enrolling Child(ren)

☐ Waiving/Removing Coverage *(check all that apply)*
☐ Waiving Medical for self in 2017
☐ Waiving Dental for self in 2017
☐ Removing coverage for Spouse
☐ Removing coverage for Child(ren)

☐ Changing Plans *(check which applies)*
☐ POS to HMO
☐ HMO to POS

Group Name and Address: **State of New Hampshire**
25 Capitol Street, Concord, NH 03301

Employee Social Security #: _____-_____-_____

Email Address:

NH FIRST ID #: _____

Work Phone:

B

Employee Name (PLEASE PRINT): First Name MI Last Name

Employee Date of Birth: *(mm/dd/yyyy)* _____/_____/_____

Home Phone:

Mailing Address (PLEASE PRINT) City State Zip Code

C

First Name MI Last Name	Add, Change or Waive/Remove	Date of Birth	Gender	Coverage Selection if Newly Adding
Employee **SAME AS ABOVE**	☐ Add or Change *(specify under Coverage Selection)* ☐ Waive Medical ☐ Waive Dental	**SAME AS ABOVE**	☐ M ☐ F	Dental ☐ Medical *(choose one)*: HMO ☐ or POS ☐
Spouse First Name MI Last Name Name:_____ SSN: _____-_____-_____	☐ Add *(specify under Coverage Selection)* ☐ Remove Medical ☐ Remove Dental	Date of Birth ___/___/_____	☐ M ☐ F	☐Dental ☐Medical
Child #1 First Name MI Last Name Name: _____ SSN: _____-_____-_____	☐ Add *(specify under Coverage Selection)* ☐ Remove Medical ☐ Remove Dental	Date of Birth ___/___/_____	☐ M ☐ F	☐Dental ☐Medical
Child #2 First Name MI Last Name Name: _____ SSN: _____-_____-_____	☐ Add *(specify under Coverage Selection)* ☐ Remove Medical ☐ Remove Dental	Date of Birth ___/___/_____	☐ M ☐ F	☐Dental ☐Medical
Child #3** First Name MI Last Name Name: _____ SSN: _____-_____-_____	☐ Add *(specify under Coverage Selection)* ☐ Remove Medical ☐ Remove Dental	Date of Birth ___/___/_____	☐ M ☐ F	☐Dental ☐Medical

****Additional children should be listed on a 2nd form****

IF NEWLY ENROLLING A SPOUSE, you must provide copy of marriage certificate **AND ONE** of the following documents: 1) Page 1 of employee's current Federal Income Tax Return **and** one of the following: a) signature page with names and signatures of employee and spouse; **or** b) email confirmation of certificate of filing listing the spouse; 2) mortgage statement; 3) home equity loan statement; 4) lease agreement; 5) automobile registration; 6) credit card or account statement; 7) utility bill; 8) property tax document. Items 2 – 7 must be dated within the last 90 days. If the document lists the spouse only, it must reflect an address that is the same as the employee's address.

IF NEWLY ENROLLING A CHILD, you must provide a copy of the birth certificate listing the employee as parent. STEP- CHILD, you must provide copy of birth certificate **and** marriage certificate listing spouse as parent. ADOPTED CHILD, you must provide copy of adoption paperwork or birth certificate listing employee as a parent. LEGAL GUARDIAN/COURT ORDER, you must provide birth certificate **and** court order signed by a judge verifying legal custody of the child; **or** Medical Support Order (QMCSO) issued by a state agency.

PLEASE REFER TO THE BENEFIT ENROLLMENT GRID FOR MORE DETAILS

Agency Name:	Agency Benefit Rep Name:	Phone #:	Date Sent to RMU:	Benefit Eff Date: **01/01/2017**	Date NH FIRST updated:	Initials:

NOTE: EMPLOYEE MUST SIGN THE ACTIVE EMPLOYEE ENROLLMENT ATTESTATION ON REVERSE SIDE OF THIS FORM

Rev 10/18/16 TH

Active Employee Benefit Enrollment Attestation

1. I acknowledge that deductions of the required contributions toward the cost of coverage will be automatically taken from my pay.
2. Benefit elections under the plan can be changed or revoked by me at each annual open enrollment or during the plan year on account of and consistent with a Special Enrollee and/or qualifying life event, or as otherwise permitted by federal law. Special Enrollee and/or qualifying life event changes will only be permitted if requested within the required timeframe and supported by required documentation.
3. I understand that benefits are governed by and subject to the conditions stated in the applicable Benefits Booklet and other governing contracts, documents and state and federal law. I further understand that plan coverage and eligibility requirements may change from time to time pursuant to changes in collective bargaining agreements and state and federal law.
4. I understand that I will be required to provide documentation supporting the eligibility of any dependents upon enrollment and from time to time thereafter. I understand that if I do not provide these documents within the specified timeframe, my dependent(s) will not be enrolled in health benefits and cannot be added until the next annual open enrollment period or qualified Special Enrollee and/or qualifying life event.
5. I understand that I am required to notify the plan of any changes in dependent eligibility, such as divorce, which makes my dependent ineligible for benefits, within the timeframes set forth in the applicable Benefits Booklet and to provide required supporting documentation to my Human Resources or Payroll Representative. I understand that my dependent(s) will not be dis-enrolled from my health benefits nor offered COBRA until the documents are received by my Human Resources or Payroll Representative. Failure to notify my Human Resources or Payroll Representative in a timely manner could result in retroactive termination and recovery of claims which I may be responsible for paying.
6. Privacy Act Statement: The information you provide on this form is needed to document your enrollment in the State's Health Benefit Plan. This information will be shared with health benefit vendors, including medical and dental carriers. We request you provide your Social Security Number (SSN), as Section 1502(a) of Public Law 111-148 requires employers to collect Social Security Numbers (SSNs) of individuals who are covered on their health benefit plan. The State uses this SSN and other information on this form to file forms reporting employer-sponsored health coverage to the IRS. Providing your SSN is not mandatory. However, while the law does not require you to supply all the information on this form, failure to provide the requested information may result in the State's inability to promptly process your enrollment. The Privacy Act (5 U.S.C. 552a(b)), as amended, prohibits the disclosure of information obtained by the State of New Hampshire in a system of records to third parties, unless the beneficiary provides a written request or explicit written consent/authorization for a party to receive such information. Where the plan participant provides written consent/proof of representation, the State will permit authorized parties to access requisite information. By signing this form, you are allowing the State to provide requisite information to authorized parties.
7. I understand that furnishing any misleading, deceptive, incomplete, or untrue statement and/or committing fraud or misrepresentation against the plan may result in termination of benefits for myself and or my dependent(s) either prospectively or retroactively. Retroactive termination may result in recovery of claims paid on behalf of myself or my dependent(s).
8. The information I have furnished is, to the best of my knowledge and belief, correct and complete.

Employee Name (printed): _____

Employee Signature: _____

Date Signed: _____ **NH FIRST ID #:** _____

For Agency Benefit Representative Use Only:	**Agency Name**	**Agency Benefit Rep Name**	**Phone #**	**Date Sent to RMU** ***(if applicable)***	**Benefit Eff Date:**	**NH FIRST Updated**	
						Date:	**Initials:**
					01/01/2017		

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